1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15996 — 5 20 am 15988

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 40 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENTON
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HARRY — Middle MASON — Last AILSTON

4. DATE OF DEATH: Month 11 — Day 11 — Year 1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		SEPT 5, 1921	46 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Self	Delaware	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ARTHUR AILSTON	MAHALA MASON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
Yes	II		Mrs. Harry Allston Denton

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left ventricular dilation due to physical strain — INTERVAL BETWEEN ONSET AND DEATH: 20 min
DUE TO (b) Arteriosclerotic Heart Disease — 5 yrs
DUE TO (c) ? history of Angina Pectoris
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Harold B. Plummer M.D.
EXAMINER'S NAME (Type): Harold B. Plummer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
22. DATE SIGNED: 11/11/67
Address (Street, city, town, or county): Preston Caroline

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 14, 1967	Denton	Denton Car. Md

24. FUNERAL DIRECTOR: Charles Moore Denton — ADDRESS:

25a. REC'D BY REGISTRAR DATE: NOV 16 1967 — 25b. REGISTRAR'S SIGNATURE: Juanita Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15997

CERTIFICATE OF DEATH

15989

1. PLACE OF DEATH
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
a. STATE Maryland — b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Goldsboro
d. STREET ADDRESS Route #1. Box 215 B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Amanda — Middle Jane — Last Anderson

4. DATE OF DEATH: Month 11 — Day 10 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: October 14 1884

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WIFE

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Kent County, Delaware

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Anderson

14. MOTHER'S MAIDEN NAME: Amanda Jane Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 221-24-4107-A

17. INFORMANT: Daughter — Mrs. Muriel E. Anderson — Address: Route #1, Box 215B Goldsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia, unknown origin — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
0534

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): malnutrition, arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 10-29, 19 67, to 11-10, 1967, that (I) ~~(we)~~ last saw the deceased alive on 11-9 19 67 and that death occurred at 8:15 A.M., from causes and on the date stated above.

22a. SIGNATURE: Stephen P Carney M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-11-67

22c. PHYSICIAN'S NAME (Type): Stephen P. Carney, M.D.

22d. ADDRESS: Easton, Md. 21601

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Nov. 13, 1967

23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery

23d. LOCATION (City or Town) (County) (State): Centreville Q.A. Co. Md.

24. FUNERAL DIRECTOR: James H. Butler - Butler Bros, Centreville, Md. — ADDRESS

25a. REC'D BY REGISTRAR DATE: NOV 14 1967

25b. REGISTRAR'S SIGNATURE

10 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15998 Items #8 & 9 Film#G394 11/15/67 ph 15990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 12 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. STREET ADDRESS: CHAPEL ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Everett — Middle: Sheldon — Last: Blades

4. DATE OF DEATH: Month: 11 — Day: 8 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 12, 1894

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: MGR OIL DISTRIBUTOR

11. BIRTHPLACE (County & State, or foreign country): TALBOT, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: BENJAMIN A. BLADES

14. MOTHER'S MAIDEN NAME: MARY ELIZA SHELDON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: SHELDON S. BLADES Jr — EASTON MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure
DUE TO (b): Calcific aortic stenosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4211
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19___ to _____, 19___, that (I) (we) last saw the deceased alive on Nov 9, 19___, and that death occurred at 10:25 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9 Nov 67

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 11-11-67

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Mem. Park

23d. LOCATION (City or Town) (County) (State): Easton TALBOT MD

24. FUNERAL DIRECTOR: [signature]

ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE: NOV 13 1967

25b. REGISTRAR'S SIGNATURE: [signature] Deputy Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15999

CERTIFICATE OF DEATH

15991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 44 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENTON
d. STREET ADDRESS: 111 North 3rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Edward — Last: Brown

4. DATE OF DEATH: Month: 11 — Day: 10 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 1,1892

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Ridgely, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Artemus Brown

14. MOTHER'S MAIDEN NAME: Unknown by family

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-12-5411

17. INFORMANT: Family
Address: 111 North 3rd St, Denton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-8, 1967, to 11-10, 1967 that (I) (we) last saw the deceased alive on 11-10 1967 and that death occurred at 8:25 A.M., from causes and on the date stated above.

22a. SIGNATURE: Stephen P. Carney M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-11-67

22c. PHYSICIAN'S NAME (Type): Stephen P. Carney, M.D.

22d. ADDRESS: Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov.18,1967

23c. NAME OF CEMETERY OR CREMATORY: Sandtown Cemetery

23d. LOCATION (City or Town) (County) (State): Hillsboro, (Caroline) MD.

24. FUNERAL DIRECTOR: C. W. Hill — ADDRESS: Denton

25a. REC'D BY REGISTRAR DATE: NOV 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

4/8 pm

16000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15992

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

M

78

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton — 20-1
d. STREET ADDRESS: 200 Glenwood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: — Last: Cobb

4. DATE OF DEATH: Month: 11 — Day: 28 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/22/54

9. AGE (In years last birthday): 13 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Jacksonville, Florida

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roosevelt Cobb

14. MOTHER'S MAIDEN NAME: Anna Mae Caldwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Anna Cobb, 200 Glenwood Ave. — Address: Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound (R) lower neck — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

9190

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. 4 p.m. 28 Nov 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Easton (County) Talbot (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Thurston Harrison M.D.

EXAMINER'S NAME (Type): THURSTON HARRISON

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 30 Nov 67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/2/67

23c. NAME OF CEMETERY OR CREMATORY: Williamsburg

23d. LOCATION (City or Town) Near Easton (County) Talbot (State) Md.

24. FUNERAL DIRECTOR: Barbara L. Dashiell, 426 Dover St. ADDRESS Easton, Md. 21601

25a. REC'D BY REGISTRAR DATE DEC 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16001

CERTIFICATE OF DEATH

15893

1 PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 30 H.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b COUNTY: Talbot
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d STREET ADDRESS: 703 S Hanson St
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Anna — Middle: Barbara — Last: Comegys

4 DATE OF DEATH: Month: 11 — Day: 17 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Aug 15 1895
9 AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (County & State, or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Gerstmyer
14. MOTHER'S MAIDEN NAME: Elizabeth Redp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Hospital Records — Address: Easton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Massive intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO (b): Chronic essential hypertension * — (?)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Cerebral atherosclerosis — (?)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1 July, 1960, to 17 Nov, 1967, that (I) (we) last saw the deceased alive on 17 Nov 1967, and that death occurred at 1:55 p M, from causes and on the date stated above.

22a SIGNATURE: Thurston Harrison — M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 18 Nov 67
22c. PHYSICIAN'S NAME (Type): THURSTON HARRISON
22d ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov 20
23c NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial
23d LOCATION (City or Town) (County) (State): Easton Talbot Md

24. FUNERAL DIRECTOR: William Cook
ADDRESS: Easton, Md
25a. REC'D BY REGISTRAR DATE: NOV 22 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16802

CERTIFICATE OF DEATH

15994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Talbot — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Queen Annes
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton — c. LENGTH OF STAY IN 1b: 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp.	d. STREET ADDRESS: 114 S. Commerce St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mildred	SEWARD	Dewing	Nov	7	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Female	White	☒ / ☐ / ☐ / ☐	Sept. 26, 1878	89 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wife	Home	Centreville Q.A.Co, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George W. Seward	Lottie A. Milby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Husband, Address
No	214-32-6616-B	T. Edmund Dewing, 114 S. Commerce St. Centreville, Md. 21617

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia, Lt. lower lobe — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Peri-rectal abcess

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on Oct. 7 1967 and that death occurred at 4:35 A.M. from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
[signature]		7 Nov 67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
E. C. H Schmidt	Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 9, 1967	Chesterfield Cemetery	Centreville, Q.A.Co. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Jos. B. Bartley Jr.	Barton Bros. Centreville, Md	NOV 13 1967	[signature]

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15995

1 PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD b. COUNTY CAROLINE
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIDGELY RURAL
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Clarence Middle Last Fisher
4 DATE OF DEATH Month Nov Day 6 Year 1967
5. SEX M
6. COLOR OR RACE C
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-29-1898
9 AGE (In years last birthday) 69 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) MD.
12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Wesley Fisher
14 MOTHER'S MAIDEN NAME Susie Simpson
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWI
16 SOCIAL SECURITY NO. 214-03-6162A
17. INFORMANT Address Maggie Fisher, Bidgely MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH 4 hrs
DUE TO (b) Chronic Cardiac Decompensation — 3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Hypertensive Arteriosclerotic Heart Disease 15 yr

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) loss of lower rightleg
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Harold B. Plummer M D
EXAMINER'S NAME (Type) Harold B. Plummer M D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) Preston Caroline
22. DATE SIGNED 11/8/67

23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b DATE THEREOF 11-10-67
23c NAME OF CEMETERY OR CREMATORY DENTON
23d LOCATION (City or Town) (County) (State) DENTON-CAROLINE MD

24 FUNERAL DIRECTOR ADDRESS B.L. Dashiell - Easton, MD.
25a REC'D BY REGISTRAR DATE NOV 13 1967
25b REGISTRAR'S SIGNATURE Wilmer Dunn

VR A15ME (5) 6M 1/67

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 (Pink) the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS Part 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

D.O.A. 10 35/pm

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16004 15996

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

M

I

1. PLACE OF DEATH a. COUNTY: Talbot, MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland b. COUNTY: Car.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgly, Md
   d. STREET ADDRESS: Rt #1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First: John Middle: O'Connor Last: Hamilton
4. DATE OF DEATH Month: 11 Day: 2 Year: 1967
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 21, 1903
9. AGE (In years last birthday): 64 yrs — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Adam Hamilton
14. MOTHER'S MAIDEN NAME: Bartie Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 220-12-1377
17. INFORMANT / Address: Blanche Hamilton Ridgely, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Fractured of Skull Left & Right Side ...
DUE TO (b) Fracture of left Femur ... — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
DUE TO (c) Fracture to Right Femur at Head

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Alcoholism Specimen Taken.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Route 404 7 miles west of Denton, Collided with a truck
20c. TIME OF INJURY Month, Day, Year Hour a.m./p.m.: 10 p.m. 11/2 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.): Route
20f. (City or town) (County) (State): Denton Caroline Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Harold B Plummer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Harold B. Plummer
Address (Street, city, town, or county)
22. DATE SIGNED: 11/4/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-6-67
23c. NAME OF CEMETERY OR CREMATORY: Union
23d. LOCATION (City or Town) (County) (State): Goldsboro, Maryland
24. FUNERAL DIRECTOR: J. E. Boulais ADDRESS: Greensboro, Md.
25a. REC'D BY REGISTRAR DATE: NOV 7 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

4/18/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

6005

CERTIFICATE OF DEATH

15987

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: 32 South Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PRESTON (Preston) Middle SAMUEL (Samuel) Last HOPE (Hope)

4. DATE OF DEATH: Month Nov. Day 23 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29, 1911

9. AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner of Retail Furniture Store

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Somerset Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Coly S. Hope

14. MOTHER'S MAIDEN NAME: Minnie F. Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 222-09-7279

17. INFORMANT Address: Stanley E. Hope, Cambridge, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma of
DUE TO
(b): the lung
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Uncertain

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ___, 19___, to ___, 19___, that (I) (we) last saw the deceased alive on 11-23-1967, and that death occurred at 5:45 A.M., from causes and on the date stated above

22a. SIGNATURE: Robert W. Trever M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Robert W. Trevor

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Nov. 26, 1967

23c. NAME OF CEMETERY OR CREMATORY: Washington Cemetery

23d. LOCATION (City or Town) (County) (State): Near Hurlock, Maryland

24. FUNERAL DIRECTOR ADDRESS: Frampton Funeral Home Federalsburg Md

25a. REC'D BY REGISTRAR DATE: NOV 29 1967

25b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16006

CERTIFICATE OF DEATH

1298

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 **PLACE OF DEATH**
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TRAPPE
c. LENGTH OF STAY IN 1b: 11 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON, MD
d. STREET ADDRESS: S. AURORA ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: NETTIE — Middle: MAY — Last: JONES

4. **DATE OF DEATH**: Month: Nov. — Day: 24 — Year: 1967

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Nov 13, 1883

9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): TALBOT, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM HELSBY

14. MOTHER'S MAIDEN NAME: MELVINA ROBINSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.

17. **INFORMANT**: ROBERT H. JONES — Address: 216 WYE AVE EASTON, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Arteriosclerotic Cardiovascular Dis — 10 yr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Spring, 1962 to Nov 24, 1967, that (I) (we) last saw the deceased alive on 22 Nov 67, and that death occurred at 5:05 A.M., from causes and on the date stated above.

22a. SIGNATURE: Raul Wroth — M.D — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11-25-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: St. Michaels Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: Nov 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: SPRINGHILL

23d. LOCATION (City or Town) (County) (State): EASTON TALBOT MD

24. FUNERAL DIRECTOR: Allen Cook — ADDRESS: Easton, MD

25a. REC'D BY REGISTRAR DATE: NOV 27 1967

25b. REGISTRAR'S SIGNATURE: Thomas Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-1. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23989

1 PLACE OF DEATH
a COUNTY: Talbot — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c LENGTH OF STAY IN 1b: DOA @ Easton
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MARYLAND
b COUNTY: DORCHESTER
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- CAMBRIDGE
d STREET ADDRESS: MADISON, MD.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Nancy Middle Marie Last KANE
4 DATE OF DEATH: Month 11 Day 3 Year 1967
5 SEX: female
6 COLOR OR RACE: negro
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: JULY 29, 1922
9 AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: JOHN L. KANE
14 MOTHER'S MAIDEN NAME: CLARIS KANE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16 SOCIAL SECURITY NO: 220-10-6342
17 INFORMANT: CLARIS KANE Address: RFD #2 CAMBRIDGE, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO
4330
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): marked cardiomegaly
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or Town) (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis J Welty M.D.
EXAMINER'S NAME (Type): Welty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
For DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
22. DATE SIGNED: 11-3-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/7/67
23c NAME OF CEMETERY OR CREMATORY: MALONES
23d LOCATION (City or Town) (County) (State): MADISON DOR. MD.

24 FUNERAL DIRECTOR: Frederick C. Loblein
ADDRESS: CAMBRIDGE, MD.
25a REC'D BY REGISTRAR DATE: NOV 6 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16009 16060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH — a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghman, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adam — Middle: Wadsworth — Last: Kapisak
4. DATE OF DEATH: Month: 11 — Day: 27 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/20/92
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul Kapisak
14. MOTHER'S MAIDEN NAME: Anna Novak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-16-5856
17. INFORMANT — Address: Mrs. Adam Kapisak, Tilghman, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:
4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Acute Myocardial Infarction — INSTANT.
DUE TO (c): Coronary Atherosclerosis. — 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on Oct. 15 1967, and that death occurred at 952 P M, from causes and on the date stated above.

22a. SIGNATURE: S. Krecht JR. M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 11.28.67
22c. PHYSICIAN'S NAME (Type): S. Krecht JR.
22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/30/67
23c. NAME OF CEMETERY OR CREMATORY: Methodist
23d. LOCATION (City or Town) (County) (State): Tilghman, Md.

24. FUNERAL DIRECTOR — ADDRESS:
25a. REC'D BY REGISTRAR — DATE: NOV 30 1967
25b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16009 — 16001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admission)
a. STATE: MARYLAND — b. COUNTY: QUEEN ANNE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SUDLERSVILLE
d. STREET ADDRESS: xx
e. S RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BEATRICE — Middle P. — Last KIRK

4. DATE OF DEATH: Month 11 — Day 16 — Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 6 1907
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: LIQUOR STORE
11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM L. WEBER
14. MOTHER'S MAIDEN NAME: AMELIA J. NEYHART

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: WILLIS KIRK — Address: LAUREL DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the lung, ant,
DUE TO (b): recurrent
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
163X
INTERVAL BETWEEN ONSET AND DEATH: 5 mo

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 5:45 A M, from causes and on the date stated above.

22a. SIGNATURE: Arthur B. Cecil — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Arthur B. Cecil, Jr., M.D.
22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Nov. 18
23c. NAME OF CEMETERY OR CREMATORY: LITTLE BRITAIN
23d. LOCATION (City or Town), (County) (State): LITTLE BRITAIN PA.

24. FUNERAL DIRECTOR — ADDRESS: Edgar L. Lane — Church Hill Md.
25a. RECD BY REGISTRAR DATE: NOV 21 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1601.0

16082

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) - DENTON
d. STREET ADDRESS: RFD #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First FLORENCE — Middle S. — Last MATLOCK

4. DATE OF DEATH: Month 11 — Day 22 — Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3-4-00
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM SMITH
14. MOTHER'S MAIDEN NAME: SARAH HALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 212-26-4713
17. INFORMANT — Address: O. J. MATLOCK, RFD #2, DENTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Uremia due to nephrosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Uncertain
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease. Congestive Heart failure.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__ to ____, 19__, that (I) (we) last saw the deceased alive on 11-22 1967, and that death occurred at 4:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D. ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 11/23/67
22c. PHYSICIAN'S NAME (Type): Robert W. Trever M.D.
22d. ADDRESS: Easton, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 25, 1967
23c. NAME OF CEMETERY OR CREMATORY: Denton Cemetery
23d. LOCATION (City or Town) (County) (State): Denton, Maryland

24. FUNERAL DIRECTOR: Harrison E Leonard — ADDRESS: St. Michael's Md
25a. REC'D BY REGISTRAR — DATE: NOV 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: the law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper—pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16011

CERTIFICATE OF DEATH

16003

1. **PLACE OF DEATH** a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 5 Yrs. 15 Mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SMITHSON RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Walter Middle: Calvin Last: McCarty

4. **DATE OF DEATH**: Month: Nov. Day: 14 Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN 9, 1906

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WALTER McCARTY

14. MOTHER'S MAIDEN NAME: ANNIE HARMON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. **INFORMANT** Address: MRS. WALTER McCARTY, PRESTON MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: < 24 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 4:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-14-67

22c. PHYSICIAN'S NAME (Type): Robert W. Trever M.D.
22d. ADDRESS: Easton, Maryland 11/14/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: NOV. 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: CONCORD
23d. LOCATION (City or Town) (County) (State): CONCORD CAROLINE MD.

24. FUNERAL DIRECTOR: CHARLES MOORE ADDRESS: EASTON

25a. REC'D BY REGISTRAR DATE: NOV 20 1967
25b. REGISTRAR'S SIGNATURE: Orlando Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16012 Item #9 Film #3-95 1/5/67 pb

CERTIFICATE OF DEATH

16004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH a. COUNTY: Talbot	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON	c. LENGTH OF STAY IN 1b: 4days	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE: MARYLAND	b. COUNTY: TALBOT	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-DENTON	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: SAMUEL	Middle: H	Last: McNEILL	4. DATE OF DEATH: Month: NOV	Day: 28	Year: 1967				
5. SEX: MALE	6. COLOR OR RACE: W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: NOV 19 1888	9. AGE (In years last birthday): 79 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): SAYBROOK, CONN	12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME: SAMUEL McNEILL	14. MOTHER'S MAIDEN NAME: TOPSY BUCKEL								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): W.W. II	16. SOCIAL SECURITY NO: 578-22-8207	17. INFORMANT: RICHARD McNEILL	Address: DENTON, MD						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Terminal pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(b): Chronic congestive heart failure — 3 months

DUE TO

(c): Arteriosclerotic heart disease — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this ~~hospital~~) attended the deceased from 11-24, 1967 to 11-28, 1967, that (I) (we) last saw the deceased alive on 11-28 1967, and that death occurred at 10:25 P.M., from causes and on the date stated above.

22a. SIGNATURE: Stephen P. Carey, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11-28-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
	DEC. 2, 1967	WICOMICO MEMORIAL	SALISBURY	WIC.	MD

24. FUNERAL DIRECTOR: R. Ellis Clark — ADDRESS

25a. REC'D BY REGISTRAR DATE: NOV 30 1967

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16013 Item #3 film [illegible] 12/1/67 pk. 16065

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial - Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENTON
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Helen — Middle McIlvaine — Last Reese

4 DATE OF DEATH: Month 11 — Day 24 — Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: AUG 18, 1895

9. AGE (In years last birthday): 72 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CHARLES McILVAINE

14. MOTHER'S MAIDEN NAME: ROSA PRICE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT Address: MRS JAS DIKE, DENTON

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
400
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Ulcer — 3 weeks
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) ~~attended~~ the deceased from 11-11, 19 67 to 11-24, 19 67, that (I) (~~we~~) last saw the deceased alive on 11-24 19 67, and that death occurred at 10 PM, from causes and on the date stated above.

22a SIGNATURE: Stephen P. Carney — M.D — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS ☐

22b DATE SIGNED: 11-27-67

22c PHYSICIAN'S NAME (Type): Stephen P. Carney, M.D.

22d ADDRESS: Easton, Maryland 11/27/67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: NOV 27, 1967

23c NAME OF CEMETERY OR CREMATORY: BARRETT'S CHAPEL

23d LOCATION (City or Town) (County) (State): FREDERICA DEL.

24a FUNERAL DIRECTOR: J. VERGIL MOORE — ADDRESS: DENTON

25a. REC'D BY REGISTRAR DATE: NOV 30 1967

25b REGISTRAR'S SIGNATURE: Richard Judge

1

16014

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16066

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton (rural)
c. LENGTH OF STAY IN 1b: 13 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Wye Cottage Farm

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton (rural)
d. STREET ADDRESS: Wye Cottage Farm
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Newbold — Last: Robinson

4. DATE OF DEATH: Month: Nov. — Day: 28 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Nov. 6, 1903

9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): M.D.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington Co. R.I.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rowland Rodman Robinson

14. MOTHER'S MAIDEN NAME: Mary Peace Hazard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 058-18-2745

17. INFORMANT: Address: Mrs. John N. Robinson, Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of the stomach with
DUE TO (b): widespread metastases
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Uncertain

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1967 to 11-28, 1967, that (I) (we) last saw the deceased alive on 11-28 1967, and that death occurred at 10:30PM, from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-29-67

22c. PHYSICIAN'S NAME (Type): Robert W. Trever M.D.

22d. ADDRESS: RD3 Easton Md. 21601

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/30/67

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park

23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON, Easton, Md.

25a. REC'D BY REGISTRAR DATE: NOV 30 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

2

16015

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16367

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY: TALBOT, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MD. b. COUNTY: QUEEN ANNES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRASONVILLE, MD.
d. STREET ADDRESS: #1 GRASONSVILLE, MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First GEORGE Middle W. Last SCOTT

4 DATE OF DEATH: Month 11 Day 2 Year 1967

5. SEX: Male
6. COLOR OR RACE: col
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-5-88
9 AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): QUEEN ANNE
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE W. SCOTT
14. MOTHER'S MAIDEN NAME: ANNA ANDERSON

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 056-16-1931
17. INFORMANT / Address: IRENE GIBSON GRASONVILLE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

	Cause	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Aspiration pneumonia	3 days
DUE TO (b)	Cerebral vascular accident	3 days
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from 31 Oct, 1967 to 11-2, 1967, that (I) (we) last saw the deceased alive on 11-2 1967, and that death occurred at 8 P M, from causes and on the date stated above.

22a. SIGNATURE: Stephen P Carney M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-3-67
22c. PHYSICIAN'S NAME (Type): Stephen P. Carney M.D.
22d. ADDRESS: Easton, Maryland 11/3/67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: NOV. 6, 1967
23c. NAME OF CEMETERY OR CREMATORY: GRASONVILLE, MD
23d LOCATION (City or Town) (County) (State): GRASONVILLE QUEEN-MD

24. FUNERAL DIRECTOR / ADDRESS: B. E. Dashiells
25a REC'D BY REGISTRAR DATE: NOV 6 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16016 — 16068

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY In Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 202 Port Street

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Easton
d. STREET ADDRESS: 202 Port Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Kenneth — Middle: — Last: Sullivan

4 DATE OF DEATH: Month: 11 — Day: 28th — Year: 1967

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 5-27-16

9 AGE (In years last birthday): 51 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: IRVIN SULLIVAN

14 MOTHER'S MAIDEN NAME: DELILAH WOOLFORD

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: UNKNOWN

17. INFORMANT: ELEANOR W. ALLEN — Address: 120 HAMMOND ST. EASTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Post alcoholic convulsive disorder — INTERVAL BETWEEN ONSET AND DEATH: 3y
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)

20c TIME OF INJURY Month, Day Year: Hour a.m. 3 p.m. 28 Nov 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street Home

20f (City or town) Easton (County) Talbot (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): THURSTON HARRISON

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county)

22 DATE SIGNED: 4 Dec 67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 12-4-67

23c NAME OF CEMETERY OR CREMATORY: Richards Memorial

23d LOCATION (City or Town) Easton (County) Talbot (State) Md.

24 FUNERAL DIRECTOR: Barbara L. Dashiell — ADDRESS: 426 Dover Street Easton, Maryland

25a REC'D BY REGISTRAR DATE: DEC 6 1967

25b REGISTRAR'S SIGNATURE: [signature]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

16617

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16669

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

D.O.A – 245 pm

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington, Va.
d. STREET ADDRESS: 2791 Washington Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sara — Middle: F. — Last: Thompson

4. DATE OF DEATH: Month: 11 — Day: 26 — Year: 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/1/1944

9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Analyst

10b. KIND OF BUSINESS OR INDUSTRY: U.S Government

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles C. Thompson

14. MOTHER'S MAIDEN NAME: Frances Meek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: 413-70-0472

17. INFORMANT: 1537 Peabody Ave., Charles C. Thompson, Memphis, Tenn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Pneumothorax left, Hemothorax — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Multiple fractures of ribs mainly right side — minutes
DUE TO (c): Unchecked Parachute fall that did not open — minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a): Many other fractures see detailed ME report

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Parachute did not open from 3000 feet

20c. TIME OF INJURY Month, Day, Year, Hour: 1:25 pm 11/6/67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.): 2miles north

20f. (City or town) (County) (State): Ridgeley Caroline Maryla

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐
Multiple X-rays were used postmortem

ACTUAL SIGNATURE: Harold B Plummer M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Harold B. Plummer M.D.
Address (Street, city, town, or county): Preston Caroline

22. DATE SIGNED: 11/27/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial / Removal

23b. DATE THEREOF: 11/29/1967

23c. NAME OF CEMETERY OR CREMATORY: Calvery Cemetery

23d. LOCATION (City or Town) (County) (State): Memphis, Tenn.

24. FUNERAL DIRECTOR: MAURICE E. NEUMAN & SON, ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: NOV 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16018 16010

1 PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hosp. Tal

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. STREET ADDRESS: R.H - Box 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Alfred — Middle: T — Last: WARNER JR

4. DATE OF DEATH: Month: 11 — Day: 27 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 10, 1885

9 AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10b KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State or foreign country): TALBOT COUNTY, MARYLAND

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ALFRED THOMAS WARNER

14. MOTHER'S MAIDEN NAME: SARA J. FOX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO: 220-01-9183

17. INFORMANT: MRS. ALFRED T. WARNER, JR. — Address: RT. 4 BOX 3 EASTON - MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia.
DUE TO (b): Arteriolar Nephrosclerosis.
DUE TO (c):
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11/17, 19 67 to 11/27, 19 67, that (I) (we) last saw the deceased alive on 11/27 1967, and that death occurred at 12 45 M, from causes and on the date stated above.

22a. SIGNATURE: S. Krech Jr. M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-28-67

22c. PHYSICIAN'S NAME (Type): S. KRECH, JR.

22d. ADDRESS: EASTON, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: NOVEMBER 30, 1967

23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL CEMETERY

23d LOCATION (City or Town) (County) (State): EASTON TALBOT MD.

24 FUNERAL DIRECTOR: Klein Bart — **ADDRESS**: Easton Md

25a. REC'D BY REGISTRAR DATE: NOV 30 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16019 16011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 62 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOUSE IN THE PINES-EASTON

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Celestia — Middle: — Last: Weatherby

4. **DATE OF DEATH**: Month: 11 — Day: 14 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/16/1895

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (County & State, or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John F. Hill

14. MOTHER'S MAIDEN NAME: Etta Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 213-24-0323

17. INFORMANT: Roy W. Rouse — Address: Lima, N.Y.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma, primary
DUE TO (b): site not determined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
1992

INTERVAL BETWEEN ONSET AND DEATH: Uncertain

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to 11-14 ..., 1967, that (I) (we) last saw the deceased alive on 11-10 ..... 1967..., and that death occured at 6:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Trewen M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-17-67

23c. NAME OF CEMETERY OR CREMATORY: Greensboro

23d. LOCATION (City, town or county) (State): Greensboro, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John E. Bohanan

ADDRESS: Greensboro, Md

25a. REC'D BY REGISTRAR DATE: NOV 17 1967

25b. REGISTRAR'S SIGNATURE: Geneva Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15023 Item 2 taken from birth certificate 1,312

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN THIS PLACE: 39 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queenstown
d. STREET ADDRESS: Dudly Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Frances — Last: Whaley
4. DATE OF DEATH: Month: 11 — Day: 28 — Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOVEMBER 26, 1967
9. AGE (In years last birthday): — yrs. — IF UNDER 1 YEAR: Months / Days 1 — IF UNDER 24 HRS: Hours + Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: RALPH CARVEL WHALEY
14. MOTHER'S MAIDEN NAME: JANICE J. COOPER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RALPH CARVEL WHALEY — Address: QUEENSTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hemorrhagic edema, pulmonary — INTERVAL BETWEEN ONSET AND DEATH
7715
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Immaturity
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on Nov 27, and that death occurred at 6:37 AM, from causes and on the date stated above

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 28 NOV 67
22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt
22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: NOVEMBER 30-1967
23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL
23d. LOCATION (City or Town) (County) (State): EASTON TALBOT MD.

24. FUNERAL DIRECTOR: R. Ellis Clark — ADDRESS
25a. REC'D BY REGISTRAR — DATE: NOV 30 1967
25b. REGISTRAR'S SIGNATURE: [signature]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15027 — 16313

1. **PLACE OF DEATH** — a. COUNTY: TALBOT — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL EASTON

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: QUEEN ANNE'S
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queen Anne, Md.
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Raymond — Middle: F. — Last: Whitby

4. **DATE OF DEATH**: Month: 11 — Day: 23 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 9-2-93

9. AGE (In years last birthday): ~~73~~ 74 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANK WHITBY

14. MOTHER'S MAIDEN NAME: ANNIE SAUNDERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: EDW. WHITBY — Address: RIDGELY, MD. — Relation: Son

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Uremic syndrome due to arteriosclerosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Uncertain

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart failure due to arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on 11-23 1967, and that death occurred at 6 p.m. from causes and on the date stated above

22a. SIGNATURE: Robert W. Trever — M.D. ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Robert W. Trever, M.D.

22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: NOV. 26, 1967

23c. NAME OF CEMETERY OR CREMATORY: GREEN MOUNT

23d. LOCATION (City or Town) (County) (State): HILLSBORO, CAR., MD.

24. FUNERAL DIRECTOR — ADDRESS: O. VERGIL MOURE DENTON

25a. REC'D BY REGISTRAR — DATE: NOV 30 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15022

CERTIFICATE OF DEATH

15014

1 PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 1/2 hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Philadelphia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia, Pennsylvania 19104
d. STREET ADDRESS: 1216 N. 42nd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: SABRA — Middle: I — Last: Williams

4 DATE OF DEATH: Month: 11 — Day: 20 — Year: 1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Female	Negro	7. MARRIED ☒	6/27/1916	51 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William A. Turner
14. MOTHER'S MAIDEN NAME: Sarah Jane Carroll

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 213-22-5765
17. INFORMANT Address: Joseph A. Williams, 1216 N. 42nd St. Philadelphia, Pa.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bilateral Pulmonary Embolii — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
(b): Varicose Vein, both leg — many year
DUE TO
(c):

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last: 460X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 12 15 P M, from causes and on the date stated above.

22a. SIGNATURE: William E Latimer MD
M.D ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 22 NOV '67
22c. PHYSICIAN'S NAME (Type): W. E. Latimer, M.D.
22d. ADDRESS: Easton, Md. (Memorial Hospital)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/25/67
23c. NAME OF CEMETERY OR CREMATORY: Richards Memorial
23d. LOCATION (City or Town) (County) (State): Easton, Talbot Maryland

24 FUNERAL DIRECTOR: B E. Dashiell
ADDRESS: 426 Dover St, Easton, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judson

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

'6923

CERTIFICATE OF DEATH

15915

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lewistown (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Md. — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lewistown Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Jenesse — Middle: — Last: Wilson

4. DATE OF DEATH: Month: II- — Day: I6 — Year: 1967

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: I2-I5-I913

9. AGE (In years last birthday): 53 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Caroline Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Dobson

14. MOTHER'S MAIDEN NAME: Ella Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 220-14-6216

17. INFORMANT: Catherine Downs Address: Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary occlusion Left Ant descen — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
(b): Hypertensive Cardio-vasc disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema of the lungs, Excessive obesity

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ____, 19__, to Nov ____, 1967, that (I) (we) last saw the deceased alive on Nov ____ 1967, and that death occurred at 8:40 M, from causes and on the date stated above.

22a. SIGNATURE: Kurt Lederer — M.D. ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 11-20-67

22c. PHYSICIAN'S NAME (Type): KURT LEDERER

22d. ADDRESS: QUEEN ANNE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: II-2I- I967

23c. NAME OF CEMETERY OR CREMATORY: Chapel

23d. LOCATION (City or Town) (County) (State): Chapel Talbot Md.

24. FUNERAL DIRECTOR: B.L. Dashiell ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: NOV 22 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16024

CERTIFICATE OF DEATH

16016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. STREET ADDRESS: AIRPORT MOTEL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HESTER Middle: Marguerite Last: WOLF

4. DATE OF DEATH: Month: NOV. Day: 6 Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 5 1900

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MOTEL MANAGER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Q.A. Co. MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MARION TANNER

14. MOTHER'S MAIDEN NAME: MARY CARTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: DANSE WOLF - EASTON MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Obstructive Uremia — Interval between onset and death: 2 wks.
DUE TO (b): Carcinomatosis — 6 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
1992

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10 30 67, 19 to 11 6, 19 67, that (I) (this) last saw the deceased alive on 11 5 19 67, and that death occurred at 2:35 P.M., from causes and on the date stated above.

22a. SIGNATURE: Robert M. McDonald M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/7/67

22c. PHYSICIAN'S NAME (Type): Robert M. McDonald, M.D.

22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Nov. 8

23c. NAME OF CEMETERY OR CREMATORY: STEVENSVILLE

23d. LOCATION (City or Town) (County) (State): STEVENSVILLE MD.

24. FUNERAL DIRECTOR: Edgar L. Lane — ADDRESS: Church Hill Md.

25a. REC'D BY REGISTRAR DATE NOV 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16025 16017

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY: Talbot	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Caroline
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton	c. LENGTH OF STAY IN 1b: 10 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital	d. STREET ADDRESS: R.F.D. # 2
	e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print): First: Norman Middle: Billeter Last: Wright	4. DATE OF DEATH: Month: 11 Day: 27 Year: 1967
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: August 31, 1899
9. AGE (In years last birthday): 68 yrs.	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired railroad man &	10b. KIND OF BUSINESS OR INDUSTRY: farmer(Penna. R.R.)
11. BIRTHPLACE (County & State, or foreign country): Caroline County	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William Grayson Wright	14. MOTHER'S MAIDEN NAME: Laura Towers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16. SOCIAL SECURITY NO.: 219-07-6172
17. INFORMANT Address: Mrs. Audrey Lee Hubbard, Hurlock, Md. R.D. #2	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ~~Cva~~ Con pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO (b): Chron obstructive pulmonary emphysem — > 5 yrs

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5271

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-17, 1967, to 11-27, 1967, that (I) (we) last saw the deceased alive on 11/27 1967, and that death occurred at 7:13 PM, from causes and on the date stated above.

22a. SIGNATURE: Stephen P. Carney M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-28-67

22c. PHYSICIAN'S NAME (Type): Stephen P. Carney M.D.

22d. ADDRESS: Easton, Maryland 11/28/67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12-1-67	Junior Order Cemetery	Preston, Maryland

24. FUNERAL DIRECTOR ADDRESS: Frampton Funeral Home Federalsburg Md.

25a. REC'D BY REGISTRAR DATE: NOV 30 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones